Standard Insurance Company
Individual Division
1100 SW Sixth Avenue Portland OR 97204-1093

Short Form Application for Disability Income Insurance GI (Guarantee Issue) Program

Proposed Insured

1. Full Name (Last, First, Middle) ______ 2. Sex ______ 3. Social Security Number ______

4. Home Address ______ City ______ State ______ Zip Code ______

5. Date of Birth ______ 6. State of Birth ______ 7. Length of US Residence ______

Insurance Applied For

8. Plan Type and Features:

Disability Income
Basic Monthly Benefit $______
Waiting Period 90 days
Benefit Period Age 67

X Indexed Cost of Living: X 3% / __ 6%
__ GI - Pre-X Waived
X GI - Pre-X Amended
__ GI - Vol. Open Enrollment
__ Supplemental Social Ins. $______
SSI Waiting Period ______ days
__ Mental Disorder/Substance Abuse Limitation
X Other FPO $7,500

X Own Occupation
X Noncancelable
X Residual Disability
__ Catastrophic $______

9. Occupation Class: ______ (Available classes: 5A, 4A, 4P, 3A, 3P, 2A, 2P, A, B)

10. Premium Mode: ______ List Bill-monthly. (List bill plan number, if known:______) ☐ Other______

11. Other Coverage: Explain YES answers in the table below. Use STATUS and TYPE codes provided.
   a. Have you applied for any disability insurance in the last 12 months? ☐YES ☐NO
   b. Is there any other individual or group disability insurance currently in force or pending on you? ☒YES ☐NO
   c. Will you become eligible for any disability insurance in the next 12 months? ☐YES ☐NO
   d. Have you applied for or received any disability insurance benefits in the last 3 months? ☐YES ☐NO
   If YES please explain:______

STATUS CODES: NOW IN FORCE (**N**); PENDING (**P**); APPLIED FOR IN THE LAST 12 MONTHS (**A**); WILL BECOME ELIGIBLE IN THE NEXT 12 MONTHS (**F**).
TYPE CODES: INDIVIDUAL (**I**); SOCIAL SECURITY SUBSTITUTE (**S**); GROUP (**G**); ASSOCIATION (**X**); OVERHEAD EXPENSE (**OE**); OTHER (**O** - EXPLAIN.)

COMPANY:	STATUS:	TYPE:	IF GROUP: WHO PAYS PREMIUM?	IF GROUP: BENEFIT CAP MAXIMUM?	MONTHLY AMOUNT:	BENEFIT PERIOD:	WAITING PERIOD:	WILL COVERAGE BE REPLACED/REDUCED?
Unum #123080	N	G	ER	$2,500	60%	Age 65	180	☒YES ☐NO
								☐YES ☐NO
								☐YES ☐NO

General Information

12. Current Primary Occupation. (Include professional designation, specialty or degree.) ______ 13. Years in Current Primary Occupation ______ 14. Years with Current Employer ______

15. Current Employer: Detroit Medical Center
16. Employer Address: 4201 E Antoine
City, State: Detroit, MI
Zip Code: 48201

17. Have you been working in your current primary occupation at least 30 hours per week, continuously for the past 6 months? ☐YES ☐NO
If NO, please explain:______

18. Have you used tobacco or nicotine in any form in the last 5 years? If yes, circle types below and complete table. ☐YES ☐NO

	HOW LONG:	AMT PER DAY:	DATE LAST USED:
A. CIGARETTES			
B. CIGAR			
C. PIPE			
D. SMOKELESS			
E. GUM, PATCH, OTHER			

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GI (Guarantee Issue) Program
Standard Insurance Company - Individual Division
1100 SW Sixth Avenue Portland OR 97204-1093

Proposed Insured (print):_______________________

Agreement

I, THE UNDERSIGNED, AGREE TO THE FOLLOWING: This application includes pages 1 and 2 and all signed application supplements and amendments. In this application, "you" and "your" mean the proposed insured unless otherwise specified. I understand that Standard Insurance Company (Standard) will rely on the information I have provided in this application in considering the proposed insured's eligibility for insurance and for various premium rates. This application will not be effective unless signed and dated by the proposed insured and owner, if different. **No insurance will be in force until the date a policy has been issued, delivered to and accepted by the owner, and the first full premium is paid while all answers in this application remain true and complete.** The only exceptions are as outlined in a written agreement between Standard and the employer as payor for the policy. Premium will be calculated to begin on the policy's Effective Date. No sales representative is authorized to judge insurability or change any of Standard's requirements. No corrections or amendments to this application may be made without the owner's written consent. We may require that any disability policy(s) listed in answer to Question 11 be permanently terminated or reduced. Standard will rely on the information in this answer in determining the amount, if any, of disability insurance it will issue. If such insurance is not terminated or reduced as required by Standard, any policy issued and accepted pursuant to this application may be rescinded and all premiums returned. If any insurance applied for is intended to replace other insurance in force with Standard, the Standard policy(s) being replaced will end the moment the insurance applied for becomes effective. I have read this application. I understand that if any answers are false, incorrect or untrue, Standard may have the right to deny benefits or rescind my insurance policy. I REPRESENT that: All answers in this application are true and complete and correctly recorded; and that any and all answers I have provided verbally to any Standard representative are recorded in this application. I signed this application in the city and state and on the date shown below.

If Proposed Insured is Owner of the Policy:

Provided there are no corrections or amendments made by Standard to this application, I AUTHORIZE my employer to accept delivery of the policy on my behalf; and I UNDERSTAND AND AGREE that my employer will then deliver the policy to me.

_______________________ Signed at_______________________ ______ on____/____/____
SIGNATURE OF PROPOSED INSURED — CITY — STATE — DATE

If Policyowner is Other Than Proposed Insured:

_______________________ Signed at_______________________ ______ on____/____/____
SIGNATURE OF POLICYOWNER — CITY — STATE — DATE

_______________________________________ _______________________
PRINT NAME AND TITLE OF POLICYOWNER — POLICYOWNER'S TAX ID NUMBER

_______________________________________ _______________________
POLICYOWNER'S ADDRESS — CITY, STATE — ZIP CODE — E-MAIL ADDRESS (OPTIONAL)

I declare and affirm that no changes, additions or alterations of any kind have been made to this form after it was signed by the proposed insured and owner (if other than the proposed insured). If this form has been sent to Standard electronically, the copy of the form sent to Standard is a true and exact copy of the original.

_______________________ Signed at_______________________ ______ on____/____/____
SIGNATURE OF SOLICITING PRODUCER — CITY — STATE — DATE

RESIDENTS OF AR, DC, KY, LA, ME, NM, OH, PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Standard Insurance Company
Individual Underwriting
1100 SW Sixth Avenue Portland OR 97204-1093

Disclosure Notice - Information Practices (Nonmedical)

Standard Insurance Company (Standard) is committed to maintaining the confidentiality of your personal information. In order to offer and administer insurance products, Standard must obtain and review a certain amount and type of personal information about you. In general, we may seek information about your age, occupation, income and finances. This personal information is obtained and disclosed by us in order to evaluate your insurability and determine appropriate premium rates; to support our normal business practices; and to provide quality service in administering policies.

Sources of Information

You and your application for insurance are our primary sources of personal information. We, or our insurance representative, may call you for a personal history interview (PHI) to obtain supplementary information or to confirm information you provide on the application. With your written authorization, we may also collect or verify personal information by contacting: insurance producers, insurance or reinsurance companies, and the Medical Information Bureau (see below); employers, and personal and business associates.

Disclosure of Information

In the course of conducting our business, there are circumstances in which we may disclose to others the information we collect about you. These disclosures are only made with your authorization, or as permitted or required by law. Such disclosures may be to the Medical Information Bureau, reinsurers; organizations that perform services or functions on our behalf or to serve you, and to regulatory, law enforcement and governmental authorities. Standard or its reinsurers may also release information in its file to other life insurance companies to whom you have applied or may apply for life or health insurance or to whom a claim for benefits may be submitted. When information is disclosed to another party to perform services or functions on our behalf, we expect them to adhere to procedures and practices that maintain the confidentiality of your personal information, to use the information only for the limited purpose for which it was shared, and to abide by all applicable federal and state privacy laws.

Review and Correction of Information

In general, you have a right to learn the nature and substance of any personal information about you in our files. You also have a right to obtain a copy of that information, subject to limited restrictions. To access information about you, send a signed, written request to the address at the top of this page. If you believe that any information about you is inaccurate, you may notify us in writing of any correction, amendment, or deletion that you believe should be made. We will carefully review your request and, where appropriate, make the necessary change.

Medical Information Bureau (MIB)

Standard, or its reinsurers, may make a brief report to the MIB. The MIB is a nonprofit membership organization of life and health insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply the company with the information in its file. At your request, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the MIB's file, you may contact the MIB and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Additional Information

We hope this information helps you understand how and why we obtain information about you. To obtain a more detailed explanation of your rights and our information practices, please contact Standard Insurance Company, Individual Underwriting, 1100 SW Sixth Ave., Portland, OR 97204-1093.

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Individual Underwriting
1100 SW Sixth Avenue Portland OR 97204-1093

Authorization to Obtain and Disclose Personal (Nonmedical) Information

Types of Personal Information Collected
I understand that it is necessary for Standard Insurance Company (Standard) to collect and review personal information about me in order to offer and administer insurance products. I understand that personal information may include information about my age, occupation, other insurance, income and finances. I also understand that personal information does not include any information related to my physical or mental condition, medical history or medical treatment.

Authorization to Obtain Personal Information
I authorize any insurance or reinsurance company, insurance sales representative, employer, the Medical Information Bureau (MIB) and any other person, organization or institution having records or knowledge of me, to release personal information about me, as described above, to Standard, its reinsurers, and any insurance support organization acting on behalf of Standard.

Authorization to Use Personal Information
I authorize Standard to use personal information obtained about me for the purposes of determining eligibility for insurance and reinsurance and determining appropriate premium rates, evaluating claims for insurance benefits, and conducting other legally permissible activities that relate to my application and insurance coverage.

Authorization to Disclose Personal Information
I authorize Standard to disclose any personal information about me to Standard's reinsurers, the Medical Information Bureau, other insurance companies to whom I have applied or may apply for insurance, and to organizations or persons, including insurance sales representatives, performing business services for Standard related to my application and policy administration. No other disclosure may be made without my further authorization except to the extent necessary for the conduct of Standard's business or as permitted or required by law.

Expiration and Revocation
I understand that I have the right to revoke this Authorization at any time by sending a written request for revocation to Standard Insurance Company, Attention: Individual Underwriting, 1100 SW Sixth Avenue, Portland, Oregon 97204. Revocation of this Authorization, or failure to sign this Authorization, will impair Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage. I realize that if I do revoke this Authorization it will not affect any use or disclosure of information prior to the receipt of my revocation and that any action taken before Standard receives my written revocation will be valid.

This Authorization will expire automatically twenty-four (24) months following the date of my signature below.

I acknowledge that I have read and received a copy of the Disclosure Notice-Information Practices. A copy of this Authorization will be provided to me, or my authorized representative, upon request. A photocopy or facsimile of this Authorization is as valid as the original. Any alteration made to this Authorization will render it invalid and unacceptable by Standard.

____
Signature of (Proposed) Insured

____
Date of Signature

____
Name (*please print*)